Georgia Child Fatality Review and the Responsibilities of Medical Personnel

Child death review is "a process that works to understand child deaths in order to prevent harm to other children. It is a collaborative process that brings people together at a state or local level, from multiple disciplines, to share and discuss comprehensive information on the circumstances leading to the death of a child and the response to that death" (National Center for Child Death Review, 2005).

Georgia Child Fatality Review

The Georgia Child Fatality Review Panel (GCFR) is a state agency that reviews local findings of individual deaths. It is governed by legislation, O.C.G.A. §§ 19-15-1 through 19-15-6. The law mandates that each county in Georgia create and maintain a child fatality review committee. Each committee is comprised of agency members representing the District Attorney's office, Juvenile Court, the County Coroner or Medical Examiner, county Health Department, county Department of Family and Children Services, local Law Enforcement agencies, and county Mental Health. Representatives from specialty areas such as prevention advocates, pediatricians, child advocates, and school nurses or social workers are also encouraged to participate in child fatality reviews. Findings from a committee's review are protected and kept confidential by legislation. The ultimate goal of fatality review is to formulate a state and/or local response to the findings which will culminate in the development of prevention plans.

The Responsibilities of Medical Personnel

O.C.G.A. 19-15-3(f) relates specifically to medical personnel in hospitals, hospices or private physician's offices. It states that "it shall be the duty of any law enforcement officer, **medical personnel**, or other person having knowledge of the death of a child to immediately notify the coroner or medical examiner of the county wherein the body is found or death occurs." 19-15-3(f) requires all persons who have knowledge of a child's death to report the death to the local coroner or medical examiner without regard to the manner or cause of death. O.C.G.A. 19-15-3(f) supersedes O.C.G.A. 45-16-24 which states that medical personnel must notify the local coroner or medical examiner if a child's death was unexpected, unusual or suspicious.

GCFR appreciates the efforts put forth by medical personnel to abide by the legislation in notifying county coroners and medical examiners of child fatalities. Their assistance in the child fatality review process supports a timely evaluation by local committees. For more information about child fatality review, please call the GCFR office at 770-528-3988 and ask for a program manager or view the website at www.gacfr.dhr.georgia.gov. Contact information for local county coroners can be found on the Georgia Coroner Association website at www.georgiacoronerassociation.org.